

Amendment No. 3 to SB0937

McNally
Signature of Sponsor

AMEND Senate Bill No. 937

House Bill No. 963*

by deleting all language after the enacting clause and substituting instead the following:

SECTION 1. Tennessee Code Annotated, Section 56-7-3301, is amended by adding the following language as new subdivisions:

() "Abuse" means billing for services that fail to meet professionally recognized standards of care or that are medically unnecessary as defined in a health insurance entity's benefit and payment policies, and provided for the financial benefit of the healthcare provider;

() "Fee schedule" means a list of maximum reimbursement amounts assigned specific codes and used by a health insurance entity pursuant to a contract between a health insurance entity and a healthcare provider to calculate payments paid to the provider for therapies, procedures, materials, and other services delivered to enrollees. For purposes of this part, "fee schedule" does not include any items listed in § 56-7-3302;

() "Fraud" means to knowingly or willfully execute, or attempt to execute, a scheme or artifice to defraud any health insurance entity or program designed to provide healthcare benefits or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health insurance entity or program designed to provide healthcare benefits, in connection with the delivery of or payment for healthcare benefits, items, or services;

() "Hospital" means a licensed public or private institution as defined in § 68-11-201;

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() "Tennessee Health Care Innovation Initiative" means the governor-led state program funded by a 2015 federal state innovations testing grant and administered by the state health care finance and administration to introduce alternative payment and health care delivery models to the TennCare program;

SECTION 2. Tennessee Code Annotated, Section 56-7-3302, is amended by deleting the section and substituting the following language:

(a) A health insurance entity shall maintain on its web site, at a minimum, the following information:

(1) A description of all coding guidelines, policies, methodologies, and any other processes that would impact coverage or payment of items and services that the health insurance entity expects to apply to the claims a provider may submit, including:

- (A) Consolidation of multiple services or charges;
- (B) Payment adjustments due to coding changes;
- (C) Payment for multiple procedures;
- (D) Payment for assistant surgeons;
- (E) Payment for the administration of immunizations and injectable medications;
- (F) Recognition of CPT code modifiers;
- (G) Definition of global surgery periods;
- (H) Payment based on the relationship of procedure code to diagnosis code;

(I) Any additional documentation needed by the health insurance entity that is necessary for payment; and

(J) Any patient data or action that is a precondition to claim payment; and

(2) A description of other applicable policies or procedures the health insurance entity may use that affect the payment of specific claims submitted by the provider, including, but not limited to, policies or procedures affecting recoupment, copayment, coinsurance, and deductibles.

(b) If the health insurance entity uses an information source outside of its control as a basis for determining the amount of payments to healthcare providers, such as Medicare, the health insurance entity shall clearly identify the source and the source's web site, if available, or the citation of the source, if the web site is not available.

(c)

(1) The health insurance entity shall maintain on its web site any methodology using a relative value system and conversion factor.

(2) If the methodology uses a relative value system, then the information on the web site shall include:

(A) The name of the relative value system;

(B) The system's version, edition, or publication date;

(C) Any applicable conversion factor, geographic factor, or adjustment applied to that relative value system; and

(D) To the extent that payment is based in whole or in part on the Medicare Resource Based Relative Value System (RBRVS), the Medicare RBRVS year.

(3) Upon written request of the provider, the health insurance entity shall provide any methodology used to determine payment amounts under the provider's contract, including, but not limited to, any methodology using a relative

value system and conversion factor, the percentage of amounts paid by the Medicare program, or a percentage of billed charges. The health insurance entity shall deliver a copy of the methodology via the contact information stipulated in the provider's contract with the health insurance entity pursuant to § 56-7-1013(g) within ten (10) business days of receipt of the provider's request.

(d) The health insurance entity shall maintain in an electronic format on its web site the publisher, product name, and edition of the software the health insurance entity uses to edit claims submitted by the provider. Nothing in this section shall require a health insurance entity to disclose or furnish proprietary information derived from a third-party source utilized by the health insurance entity in developing the policies, procedures, methodologies, guidelines, or processes encompassed by this section.

(e) For any denials, edits, or adjustments to a healthcare provider's payment based on any guideline, policy, procedure, methodology, or process required to be disclosed under this section, but not so disclosed, the commissioner shall have the authority to review any provider claims affected by the nondisclosure.

SECTION 3. Tennessee Code Annotated, Title 56, Chapter 7, Part 33, is amended by deleting § 56-7-3304 and adding the following language as new sections:

56-7-3304.

(a) No health insurance entity shall make a change or changes to a provider's fee schedule except as follows:

(1) Up to one (1) time during a consecutive twelve-month period. After a health insurance entity makes a change or changes to the provider's fee schedule, it is prohibited from doing so again for at least twelve (12) months following the effective date of the change or changes; or

(2) If the health insurance entity and a hospital agree to the change or changes in writing.

(b) Subsection (a) does not apply to the following changes to a fee schedule:

(1) Any change in the provider's fee schedule due to a change effected by the federal or state government to its healthcare fee schedule if the provider and health insurance entity have previously agreed that the provider's fee schedule is based on a percentage, or some other formula, of a current government healthcare fee schedule, such as Medicare;

(2) Any change in the provider's reimbursement for drugs, immunizations, injectables, supplies, or devices if the provider and health insurance entity or pharmacy benefits manager as defined in § 56-7-3102 have previously agreed that any reimbursement for drugs, immunizations, injectables, supplies, or devices will be based on a percentage, or some other formula, of a price index not established by the health insurance entity, such as the average wholesale price or average sales price;

(3) Any changes in the provider's reimbursement for drugs, immunizations, injectables, supplies, or devices if the provider and the health insurance entity or pharmacy benefits manager as defined in § 56-7-3102 have previously agreed to any reimbursement for drugs, immunizations, injectables, supplies, or devices in accordance with § 56-7-3104 and based upon maximum allowable cost pricing as regulated by §§ 56-7-3101 and 56-7-3106;

(4) Any change to Current Procedural Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes, International Statistical Classification of Disease and Related Health Problems (ICD) codes, and other coding sets recognized or used by the Centers for Medicare and Medicaid Services (CMS) that the health insurance entity utilized in creating the provider's fee schedule;

(5) Any change to revenue codes as established by the National Uniform Billing Committee (NUBC); and

(6) Any changes in the provider's fee schedule due to one (1) or more of the following if previously agreed to in the provider's agreement with the health insurance entity:

(A) Payments made to the healthcare provider by the health insurance entity or payments made to the health insurance entity by the provider that are based on values or quality measures explicitly described in the written agreement between the provider and the health insurance entity intended to improve care provided to the health insurance entity's members;

(B) Escalator or de-escalator clauses;

(C) Provisions that require adjustments to payment due to population health management performance or results; or

(D) Any arrangements, initiatives, or value-based payments relating to or resulting from the implementation or operation of the Tennessee Health Care Innovation Initiative.

(c) Nothing in this section shall apply to an enrollee's benefit package, or coverage terms and conditions, unrelated to application of fee schedules and reimbursements, including, but not limited to, provisions regarding eligibility for coverage, deductibles and copayments, coordination of benefits, and coverage limitations and exclusions.

(d) Nothing in this section shall apply to any entity that is subject to delinquency proceedings and for which the commissioner of commerce and insurance has been appointed receiver, or any entity placed under administrative supervision by order of the commissioner pursuant to the Insurers Rehabilitation and Liquidation Act, compiled in chapter 9 of this title.

56-7-3305.

(a) A health insurance entity shall not make a change or changes to any of the policies, procedures, or methodologies described in § 56-7-3302 on more than four (4) dates during a consecutive twelve-month period.

(b) The following changes are excluded from the restriction in subsection (a) and may be effected by a health insurance entity at any time:

(1) Changes to the coding standards and claims edits of the Healthcare Common Procedure Coding System (HCPCS) published by the Centers for Medicare and Medicaid Services (CMS); the Current Procedural Terminology (CPT) published by the American Medical Association (AMA); and revenue codes published by the National Uniform Billing Committee (NUBC);

(2) Any change related to utilization review, as defined in § 56-6-703 and addressed in the Health Care Service Utilization Review Act, compiled in chapter 6, part 7 of this title;

(3) If the health insurance entity and a hospital agree to the change or changes in writing;

(4) Any changes due to one (1) or more of the following if previously agreed to in the provider's agreement with the health insurance entity:

(A) Payments made to the healthcare provider by the health insurance entity or payments made to the health insurance entity by the provider that are based on values or quality measures explicitly described in the written agreement between the provider and the health insurance entity intended to improve care provided to the health insurance entity's members;

(B) Escalator or de-escalator clauses;

(C) Provisions that require adjustments to payment due to population health management performance or results; or

(D) Any arrangements, initiatives, or value-based payment methodologies relating to or resulting from the implementation or operation of the Tennessee Health Care Innovation Initiative; or

(5) Any changes to drug formularies if the formulary is changed according to the standards as set out by the health insurance entity or pharmacy benefits manager as defined in § 56-7-3102.

(c) Nothing in this section shall apply to an enrollee's benefit package, or coverage terms and conditions, unrelated to application of fee schedules and reimbursements, including, but not limited to, provisions regarding eligibility for coverage, deductibles and copayments, coordination of benefits, and coverage limitations and exclusions.

(d) A health insurance entity shall notify a healthcare provider of its intent to effect a change as described in subsection (a) at least ninety (90) calendar days prior to the effective date of the change. The notice shall be provided to the individual or address stipulated in the parties' contract pursuant to § 56-7-1013(g) and shall contain an explanation of the change and the citation, section, or page number within the health insurance entity's policy or manual where the change is located. The health insurance entity shall disclose or identify the change through the use of bold print or a font, or both, with the bold print or font being the same or larger size as the font generally used throughout the policy or manual.

(e) Actions taken by a health insurance entity to determine whether a healthcare provider is committing fraud are exempt from the scope of subsection (a).

(f) Actions taken by a health insurance entity to determine whether a healthcare provider is abusing the billing for reimbursement for healthcare services rendered are exempt from the scope of subsection (a).

(g) Nothing in this section shall apply to any entity that is subject to delinquency proceedings and for which the commissioner of commerce and insurance has been

appointed receiver or any entity placed under administrative supervision by order of the commissioner pursuant to the Insurers Rehabilitation and Liquidation Act, compiled in chapter 9 of this title.

56-7-3306.

(a) If a health insurance entity offers a healthcare provider, via a contract amendment, the opportunity to participate in a health plan or provider network with which the provider is not currently participating, the health insurance entity shall send the contract amendment, including the information listed in subsection (b), at least forty-five (45) days prior to the effective date of the amendment to the individual or address stipulated in the parties' contract pursuant to § 56-7-1013(g).

(b) In addition to the contract amendment, the health insurance entity shall also disclose:

(1) The fee schedule associated with the new health plan or provider network, if the fee schedule is not one under which the provider is already contracted; and

(2) If the provider will be terminated from all or any other of the health insurance entity's health plans or provider networks with which the provider is currently participating if the provider chooses not to participate in the new health plan or provider network.

56-7-3307. Nothing in this part shall prohibit either a health insurance entity or a provider from terminating a contract for the provision or payment of healthcare services in accordance with mutually agreed-upon terms.

56-7-3308.

(a) Nothing in this part shall apply to the TennCare program or any successor Medicaid program provided for in title 71, chapter 5; the CoverKids Act of 2006, compiled in title 71, chapter 3, part 11; the Access Tennessee Act of 2006, compiled in title 56, chapter 7, part 29; any other plan managed by the health care finance and

administration division of the department of finance and administration or any successor division or department; or the group insurance plans offered under title 8, chapter 27.

(b) Notwithstanding anything in this part to the contrary, this part shall not apply to any contract amendment that is made due to a change in federal or state law.

(c) Nothing in this part shall apply to any contract between a health insurance entity and healthcare provider for items or services to be provided for individuals covered by any Medicare Advantage, Medicare Select, Medicare Supplement, Medicare and Medicaid Enrollees (MME), Medicare Dual Special Needs, or Medicare Private Fee for Service; or the state, local government, and local education insurance plans established under title 8, chapter 27.

SECTION 4. Tennessee Code Annotated, Section 56-7-1013, is amended by deleting the section and substituting the following language:

(a) As used in this section:

(1) "Fee schedule" shall have the same meaning as set forth in § 56-7-3301;

(2) "Healthcare provider" or "provider" shall have the same meaning as set forth in § 56-7-110(a);

(3) "Health insurance entity" shall have the same meaning as set forth in § 56-7-109(a); and

(4) "Hospital" means a licensed public or private institution as defined in § 68-11-201.

(b) Health insurance entities shall provide or make available to a healthcare provider, when contracting or renewing an existing contract with the provider, the payment or fee schedule and all other information sufficient to enable the healthcare provider to determine the manner and amount of payments under the contract for the healthcare provider's services prior to final execution or renewal of the contract. The payment or fee schedule and all other information submitted to a healthcare provider

pursuant to this section shall include a description of processes and factors that may be applicable and that may affect actual payment, including copayments, coinsurance, and deductibles. A health insurance entity, upon request of a healthcare provider, shall make available to the healthcare provider examples of actual payment for procedures frequently performed by the provider that involve combinations of services or payment codes, if the actual payment for the procedures cannot be ascertained from the fee schedule or other information submitted to a healthcare provider pursuant to this section.

(c) Health insurance entities shall provide a healthcare provider access, free of charge, to that provider's individual fee schedule, either a partial or full version, at the request of the provider, in an industry standard spreadsheet format. A health insurance entity, at its discretion, shall provide the fee schedule in one (1) of the following formats:

(1) Deliver the provider's fee schedule via electronic mail to an address stipulated in the provider's contract with the health insurance entity. The fee schedule shall be sent within ten (10) business days of the receipt of a provider's written request; or

(2) Maintain the provider's fee schedule on a secure web site, so that the provider may access the fee schedule at any time throughout the term of the provider's contract with the health insurance entity.

(d) At the written request of the provider, a health insurance entity may deliver a paper copy of the provider's fee schedule, either a partial or full version, at the request of the provider, via U.S. mail. The health insurance entity may charge the provider a reasonable fee to mail the fee schedule. The fee schedule shall be sent within fifteen (15) business days of receipt of the provider's request.

(e) Health insurance entities shall provide notice of and identify any change to a provider's fee schedule, excluding those listed under § 56-7-3304(b), at least ninety (90) days prior to the effective date of the change using the notice procedures in the healthcare provider's contract with the health insurance entity.

(f) A health insurance entity shall not require any hospital, by contract, reimbursement, or otherwise, to notify the health insurance entity of a hospital inpatient admission within less than one (1) business day of the hospital inpatient admission if the notification or admission occurs on a weekend or federal holiday. Nothing in this subsection (f) shall affect the applicability or administration of other provisions of a contract between a hospital and a health insurance entity, including, but not limited to, preauthorization requirements for scheduled inpatient admissions.

(g) The health insurance entity shall stipulate in its contract with the healthcare provider the specific name or position and the address, either electronic or physical, to which the healthcare provider shall send any notices or requests contemplated or required by this section or under the parties' contract. The healthcare provider shall stipulate in its contract with the health insurance entity the individual, the specific name or position, and the address, either electronic or physical, to which the health insurance entity shall send any notices or requests contemplated or required by this section or under the parties' contract.

(h) The healthcare provider or the health insurance entity, as applicable, shall notify the other party within ten (10) business days of any change in the individual or address stipulated in the contract pursuant to subsection (g).

(i) A healthcare provider receiving information pursuant to subsection (b) or subsection (c) shall not share the information with an unrelated person without the prior written consent of the health insurance carrier. The remedies available to a health insurance carrier to enforce this subsection (i) shall include, but not be limited to, injunctive relief. A health insurance carrier seeking extraordinary relief to enforce this subsection (i) shall not be required to establish irreparable harm with regard to the sharing of competitively sensitive information.

(j) This section shall not apply to nonprofit dental service corporations established under chapter 30 of this title.

(k) Nothing in this part shall apply to any contract between a health insurance entity and healthcare provider for items or services to be provided for individuals covered by any Medicare Advantage, Medicare Select, Medicare Supplement, Medicare and Medicaid Enrollees (MME), Medicare Dual Special Needs, or Medicare Private Fee for Service; or the state, local government, and local education insurance plans established under title 8, chapter 27.

(l) Notwithstanding anything in this section to the contrary, this section shall not apply to any contract amendment that is made due to a change in federal or state law.

SECTION 5. Tennessee Code Annotated, Section 56-7-110, is amended by deleting subsection (h) and substituting the following language:

(h)

(1) A provider may request a copy of the policies or fee schedule that were in effect during the audit period within ten (10) business days of receipt of notification that the health insurance entity's audit is complete. The request shall be made in writing to the health insurance entity's designated address.

(2) Health insurance entities shall furnish or make available payment policies that were in effect during the audit period within ten (10) business days after receiving the written request.

SECTION 6. This act shall take effect July 1, 2017, the public welfare requiring it and shall apply to all contracts, renewals, and amendments entered into by a healthcare provider and a health insurance entity on or after that date.